Patient Information:

First Name:_____Last:_____MI:_____Social Security #_____

Address:_____E-mail_____

City:_____State_____Zip Code_____

Home Phone:_____Cell Phone:_____

Male ☐Female ☐ Birthdate_____Age_____☐Single ☐Married ☐Widowed ☐Other

Patient Employer/School_____Occupation/Grade_____

Whom may we thank for referring you? _____

Name of emergency contact?_____Relationship_____Phone____

Preferred method of contact: ☐Phone ☐ Email ☐Mail

Lifestyle Questionnaire: Do You... (check box if your answer is yes)

□ Work at a computer? (Hours per day?_____)
□ Wear Lined Bifocals and you are bothered by them?
□ Think you might benefit from thinner, lighter lenses?
□ Have interest in a "test drive" of the latest contact lens designs?
□ Spend time outdoors? (Hours per day?_____)
□ Have prescription sun wear?
□ Prefer not to wear your glasses at times?
□ Have more than 1 pair of current RX Eyewear?
□ Have children?
□ Have family Members in need of eye care?
☐Other_____

Authorization to Pay Benefits to Provider

I hereby authorize payment directly to all providers of the medical benefits, if any: otherwise, payable to me for service rendered by (Aesthetic Eye Care). I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible. I also agree that in the case of default of payment I will be responsible for any costs incurred in the collection of such an account including reason attorney fees and court costs I hereby waive notice of dishonor, demand, and protest. All exemptions are waived. I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit and I am responsible for the payment to Aesthetic Eye Care for all service rendered the above patient that are not covered by Medicare assignment, Medicaid, or other benefits agreed by the provider of such services. I certify that the information contained herein is complete and correct. I authorize photocopies of this form to be valid as the original.

Patient or Guardian Signature_____**Date**_____

Release of Medical Records

To: Custodian of Medical records. This authorizes you to release to Aesthetic Eye Care full and complete medical records, reports, evaluations, consultations, or information (collectively referred to as "medical records") you may have in custody concerning the undersigned patient. The undersigned represent and warrants that he/she has full authority to request said records and to agree to all the conditions recited herein. The undersigned expressly released and forever discharges and agrees to indemnify and hold harmless Aesthetic Eye Care including its owner and employees, from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising out of or from the release of any medical records pursuant to this authorization.

Patient or Guardian Signature_____**Date**_____

Acknowledgement of Privacy Policy: Aesthetic Eye Care

Patient or Guardian Signature_____**Date**_____

Medical History: Current Medical Dr:_____ List any allergies to medicines or other substances:_____ List any medications you are taking:

_____

List any recent hospitalization or surgery:_____

Patient Eye History:

Date of Last Eye Exam:_____By Whom: _____ Have you ever tried Contact Lenses?_____Yes__No

Do you currently wear Contact Lenses?____Yes____ No If yes, what kind?_____

_____

Solutions Used_____

_____

How often do you replace your lenses?

_____

How many hours do you wear your lenses?

_____

Review of Symptoms: Do you currently, or have you ever had any problems in the following areas:

System	Yes	No	System	Yes	No
Eyes			**Vascular/Heart**		
Loss of Vision	___	___	Diabetes	___	___
Blurred Vision	___	___	High Blood Pressure	___	___
Double Vision	___	___	Heart Pain	___	___
Eye Injury	___	___	**Neurological**		
Eye Surgery	___	___	Headaches	___	___
Floaters/Flashes	___	___	Migraines	___	___
Glare/Halos	___	___	Seizures	___	___
Crossed or Lazy Eye	___	___	**Respiratory**		
Cataracts	___	___	Asthma	___	___
Glaucoma	___	___	Chronic Bronchitis	___	___
Eye pain or soreness	___	___	Emphysema	___	___
Retinal Disease	___	___	**Skin**	___	___
Dry Eyes	___	___	**Psychiatric**	___	___
Iritis/Uveitis	___	___	**Gastrointestinal**	___	___
Endocrine			Diarrhea	___	___
Thyroid	___	___	Ear/Nose/Throat/Mouth		
Bones/Joints/Muscles			Allergies/Hay Fever	___	___
Rheumatoid Arthritis	___	___	**Genitourinary**		
Joint Pain	___	___	Kidney/Bladder/Genital	___	___
Hematologic			**Social History:**		
Anemia	___	___	Do you drink alcohol?	___	___
			(If yes, how much?)	_____	
			Do you use tobacco products?	___	___

Family History: Please note any family history (parents, grandparents, siblings, and/or children-living or deceased) for the following conditions:

Ocular Condition	**Yes**	**No**	**If so, who?**	**Systemic Condition**	**Yes**	**No**	**If so, who?**
Blindness	___	___	_____	Diabetes	___	___	_____
Crossed Eyes	___	___	_____	High Blood Pressure	___	___	_____
Glaucoma	___	___	_____	Cancer	___	___	_____
Macular Degeneration	___	___	_____	Heart Disease	___	___	_____
Retinal Detachment	___	___	_____				

By signing this form, I consent to treatment for myself and/or on behalf of the Minor for which this information pertains. I give permission for the doctor/s to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of Minor and have the authority to authorize care and treatment.

Patient/Parent or Guardian_____**Date:** _____